Background

Worldwide, tuberculosis (TB) is one of the most deadly infectious diseases. Although it is curable and preventable, TB claims the lives of more than 5,000 people every day (nearly 2 million deaths per year) (World Health Organization [WHO], 2006). TB disproportionately affects poor and marginalized groups of society who are often at higher risk for TB, both around the world and in the United States (Dubos & Dubos, 1952; Mitnick, Furin, Henry, & Ross, 1998; Sepkowitz, 2001).

Domestically, the number of TB cases has decreased steadily since 1992, but this reduction has not affected all populations equally. In 2005, the TB case rate among foreign-born persons was almost nine times that of persons born in the United States (21.9/100,000 compared with 2.5/100,000). The same year, 55% of all TB cases in the United States were among foreign-born persons (Centers for Disease Control and Prevention [CDC], 2006b). Most cases among this group result from reactivation of latent TB infection (LTBI) acquired in countries of birth with high TB prevalence (Zuber, McKenna, Binkin, Onorato, & Castro, 1997).

The high incidence of TB in the United States among foreign-born persons poses challenges to public health programs across the country (CDC, 2006b). Although disparities between U.S.-born and foreign-born TB patients are caused by multiple factors, persons born outside the United States often face challenges related to personal or cultural beliefs, behaviors, and needs when accessing TB services. Attempts to control TB in foreign-born populations have sometimes been hindered by cultural and linguistic barriers, as well as challenges related to resettlement, employment, and socioeconomic position. Understanding these issues is crucial to the prevention and control of TB among foreign-born populations.

Cultural Competency in Tuberculosis Service Delivery

Cultural competence is an essential element of quality health care and can help improve health outcomes, increase clinic efficiency, and produce greater patient satisfaction (Brach & Fraser, 2000). Although there is no universally accepted definition of cultural competence, it may generally be understood to be a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. Furthermore, it reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of patients and their families in order to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups (U.S. Office of Minority Health, 2006). Linguistically appropriate services are a key component of culturally competent health systems. In 2001, the U.S. Office of Minority Health issued Culturally and Linguistically Appropriate Service (CLAS) standards to help health care organizations move toward cultural competence (see Appendix C). Several of these standards are federal mandates supported by Title VI of the Civil Rights Act (1964), which prohibits discrimination on the basis of national origin and language. In summary, these standards aim to ensure that all federally funded health facilities provide services in a language understood by patients.

To move towards cultural competence, health care providers and other program staff should understand the ethnic and cultural needs of the populations they serve. Providing effective care involves taking the time to learn from patients what is important to them in the experience of illness and treatment. According to medical anthropologist Arthur Kleinman, finding out "what is at stake" for the individual will provide crucial information to use in communication and in tailoring a treatment plan (Kleinman & Benson, 2006). Culture does matter in the clinic, and providers must remember that they too bring a cultural perspective to the patient-provider relationship. Increasing staff knowledge of the cultural and ethnic backgrounds of populations served is one important aspect of the CLAS standards.

Considerations When Using This Guide

Although the information in this publication was gathered from many sources, it will not apply to all Somalis in the United States. Somali culture, as all others, is dynamic. Cultural perspectives may vary depending upon a person's age, sex, education, social class, or degree of acculturation. To ensure that TB services are both sensitive and appropriate, users of this guide are encouraged to use an approach grounded in an understanding of the cultural background of those served, while also appreciating each patient's individuality and uniqueness.

Further, providers must also recognize their own beliefs and biases, as these may inadvertently be communicated to patients and families. Awareness of one's own verbal and nonverbal communication styles will help avoid social gaffes that may offend others and adversely affect the relationship. Good patient-provider relationships are built on trust and respect; therefore, providers wishing to care effectively for their patients should heighten their sensitivities to both differences and similarities and use knowledge to guide their practice (Lipson & Dibble, 2005).

Somali children outside their home in Kenya.
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